FACTOR VIII CONJUGATES

CROSS REFERENCE TO RELATED APPLICATIONS

This application is a continuation of U.S. patent application Ser. No. 11/273,896 filed on Nov. 14, 2005 (now U.S. Pat. No. 7,632,921), which claims benefit of priority to U.S. Patent App. Ser. No. 60/627,277 filed on Nov. 12, 2004, both of which applications are hereby incorporated by reference herein in their entireties.

FIELD OF THE INVENTION

This invention relates to Factor VIII (FVIII) muteins that allow coupling, at a defined site, to one or more biocompatible polymers such as polyethylene glycol. In addition, related formulations, dosages and methods of administration thereof for therapeutic purposes are provided. These modified FVIII variants, and associated compositions and methods are useful in providing a treatment option with reduced injection frequency and reduced immunogenic response for individuals afflicted with hemophilia A.

BACKGROUND OF THE INVENTION

Hemophilia A is the most common hereditary coagulation disorder, with an estimated incidence of 1 per 5000 males. It is caused by deficiency or structural defects in FVIII, a critical component of the intrinsic pathway of blood coagulation. The current treatment for hemophilia A involves intravenous injection of human FVIII. Human FVIII has been produced recombinantly as a single-chain molecule of approximately 300 kD. It consists of the structural domains A1-A2-B-A3-C1-C2 (Thompson, 2003, Semin. Hematol. 29, pp. 11-22). The precursor product is processed into two polypeptide chains of 200 kD (heavy) and 80 kD (light) in the Golgi Apparatus, with the two chains held together by metal ions (Kaufman et al., 1988, J. Biol. Chem. 263, p. 6352; Andersson et al., 1986, Proc. Natl. Acad. Sci. 83, p. 2979).

The B-domain of FVIII seems to be dispensable as B-domain deleted FVIII (BDD, 90 kD A1-A2 heavy chain plus 80 kD light chain) has also been shown to be effective as a replacement therapy for hemophilia A. The B-domain deleted FVIII sequence contains a deletion of all but 14 amino acids of the B-domain.

Hemophilia A patients are currently treated by intravenous administration of FVIII on demand or as a prophylactic therapy administered several times a week. For prophylactic treatment 15-25 IU/kg bodyweight is given of factor VIII three times a week. It is constantly required in the patient. Because of its short half-life in man, FVIII must be administered frequently. Despite its large size of greater than 300 kb for the full-length protein, FVIII has a half-life in humans of only about 11 hours. (Ewenstein at al, 2004, Semin. Hematol. 41, pp. 1-16). The need for frequent intravenous injection creates tremendous barriers to patient compliance. It would be more convenient for the patients if a FVIII product could be developed that had a longer half-life and therefore required less frequent administration. Furthermore, the cost of treatment could be reduced if the half-life were increased because fewer dosages may then be required.

An additional disadvantage to the current therapy is that about 25-30% of patients develop antibodies that inhibit FVIII activity (Saenko et al, 2002, Haemophilia 8, pp. 1-11). The major epitopes of inhibitory antibodies are located within the A2 domain at residues 484-508, the A3 domain at residues 1811-1818, and the C2 domain. Antibody development prevents the use of FVIII as a replacement therapy, forcing this group of patients to seek an even more expensive treatment with high-dose recombinant Factor VIIa and immune tolerance therapy.

The following studies identified FVIII epitopes of inhibitory antibodies. In a study of 25 inhibitory plasma samples, 11 were found to bind to the thrombin generated 73 kD light chain fragment A3C1C2, 4 to the A2 domain, and 10 to both (Fulcher, C. at al., 1985, Proc. Natl. Acad. Sci. 2(22), pp. 7728-32). In another study, six of eight A2 domain inhibitors from patients were neutralized by a recombinant A2 polypeptide (Scandella, D. et al., 1993, Blood 82(6), pp. 1767-75). Epitopes for six of nine inhibitors from patients were mapped to A2 residues 379-538 (Scandella, D. at al., 1988, Proc. Natl. Acad. Sci. 85(16), pp. 6152-6). An epitope for 18 heavy-chain inhibitors was localized to the same N-terminal 18.3 kD region of the A2 domain (Scandella, D. et al., 1989, Blood 74(5), pp. 1618-26).

An active, recombinant hybrid human/porcine FVIII molecule, generated by replacing human A2 domain residues 387-604 with the homologous porcine sequence, was resistant to a patient A2 inhibitor (Lubin, I. at al., 1994, J. Biol. Chem. 269(12), pp. 8639-41) and resistant to a murine monoclonal antibody mAB 413 IgG that competes with patient A2 inhibitors for binding to A2 (Scandella, D. et al., 1992, Thromb Haemost. 67(6), pp. 665-71). This A2 domain epitope was further localized to the A2 domain residues 484-508 when experiments showed that mAB 413 IgG and four patient inhibitors did not inhibit a hybrid human/porcine FVIII in which the A2 domain residues 484-508 were replaced with that of porcine (Healey, J. at al., 1995, J. Biol. Chem. 270(24), pp. 14505-9). This hybrid FVIII was also more resistant to at least half of 23 patient plasmas screened (Barrow, R. et al., 2000, Blood 95(2), pp. 564-8). Alanine scanning mutagenesis identified residue 487 to be critical for binding to all five patient inhibitors tested, while residues 484, 487, 489, and 492 were all important to interaction with mAB 413 IgG (Lubin, I., J. Biol. Chem. 272(48), pp. 30191-5). Inhibitory antibody titers in mice receiving the R484A/R489A/P492A mutant, but not the R484A/R489A mutant, were significantly lower than in mice receiving control human BDD FVIII (Parker, E. et al., 2004, Blood 104(3), pp. 704-10). In sum, the 484-508 region of the A2 domain seems to be a binding site for inhibitors of FVIII activity.

In addition to the development of an immune response to FVIII, another problem with conventional therapy is that it requires frequent dosaging because of the short half-life of FVIII in vivo. The mechanisms for clearance of FVIII from the circulation have been studied.

FVIII clearance from circulation has been partly attributed to specific binding to the low-density lipoprotein receptor-related protein (LRP), a hepatic clearance receptor with broad ligand specificity (Oldenburg et al., 2004, Haemophilia 10 Suppl 4, pp. 133-139). Recently, the low-density lipoprotein (LDL) receptor was also shown to play a role in FVIII clearance, such as by cooperating with LRP in regulating plasma levels of FVIII (Bovenschen et al., 2005, Blood 106, pp. 906-910). Both interactions are facilitated by binding to cell-surface heparin sulphate proteoglycans (HSPGs). Plasma half-life in mice can be prolonged by 3.3-fold when LRP is blocked or 5.5-fold when both LRP and cell-surface HSPGs are blocked (Sarafanov et al., 2001, J. Biol. Chem. 276, pp. 11970-11979). HSPGs are hypothesized to concentrate FVIII on the cell surface and to present it to LRP. LRP binding sites on FVIII have been localized to A2 residues 484-509 (Saenko et al., 1999, J. Biol. Chem. 274, pp. 37685-37692), A3 resi-